J. Endocrine, Nutritional, and Metabolic Diseases and Disorders

(1) ~~Treated with~~ Major surgical procedures	~~285-288~~ 285-293	
(2) Diabetes, ~~Age > 35~~ all ages	294, 295	
(3) ~~Diabetes, Age 0-35~~ [Reserved for future use]	~~295~~	
(4) Nutritional and metabolic disorders, age 0-17	~~296-299~~ 298	
(5) ~~[Reserved for future use]~~ Other endocrine, nutritional, and metabolic conditions	296, 297, 299, 300, 301	
(6) ~~[Other edocrine, nutritional, and metabolic conditions~~	~~289-293, 300, 301~~	~~Codes in DRG 292 except 52.80-52.86~~
[Reserved for future use]		

K. Kidney and Urinary Tract Conditions

(1) Renal failure and renal system procedures	~~303, 304, 305~~ 303-305, 315, 316	
(2) ~~Treated with~~ Other surgical ~~procedure~~ procedures	~~306-315~~ 306-314	
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) Other kidney and urinary tract conditions	317-333	
(6) [Reserved for future use]		
~~(7) [Reserved for future use]~~		
~~(8) [Reserved for future use]~~		

L. Male Reproductive System Conditions 334-352

M. Female Reproductive System Conditions

(1) ~~[Reserved for future use]~~ Major female reproductive system OR procedures	353, 354, 360, 365
(2) ~~[Reserved for future use]~~ Other female reproductive system OR procedures	355-359,361-364
(3) Female reproductive system malignancy and infection	366, 367, 368
(4) Menstrual and other female reproductive system disorders	369
(5) ~~[Other Female Reproductive System Conditions~~	~~353-360, 365-367~~
[Reserved for future use]	

(6) ~~Treated with Tubal Interruption, D&C, Conization, or Radio Implant~~ ~~361-364~~ [Reserved for future use]

N. Pregnancy Related Conditions
(1) [Reserved for future use]
(2) [Reserved for future use]
(3) Postpartum and post abortion conditions treated without surgical procedure 376
(4) Postpartum and post abortion conditions treated with surgical procedure 377
(5) Ectopic pregnancy 378
(6) Threatened abortion 379
(7) Abortion without D & C 380
(8) Abortion with D & C, aspiration curettage or hysterotomy 381
(9) False labor 382
(10) Other antepartum conditions 383, 384

O. [Reserved for future use]

P. Blood and Immunity Disorders
(1) ~~Treated with~~ Surgical procedure of the blood and blood forming organs 392-394
(2) ~~[Reserved for future use]~~ Red blood cell and other disorders without CC 395, 396, 399
(3) ~~Red blood cell disorders, Age > 17~~ ~~395~~ [Reserved for future use]
(4) ~~Red blood cell disorders, Age 0-17~~ ~~396~~ [Reserved for future use]
(5) Reticuloendothelial and immunity with CC and coagulation disorders 397, 398
(6) ~~Reticuloendothelial and immunity disorders~~ ~~398, 399~~ [Reserved for future use]

Q. Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms
(1) [Reserved for future use]
(2) [Reserved for future use]

(3)	[Reserved for future use]	
(4)	Treated with radiotherapy or chemotherapy	409, 410, 492
(5)	[Reserved for future use]	
(6)	Other treatments for myeloproliferative diseases and disorders	400-408, 411-414, 473

R. Infections and Parasitic Diseases

(1)	Treated with surgical procedure	415
(2)	Viral and other infection, parasitic diseases, and fever of unknown origin	418-423
(3)	Septicemia age > 17	416
(4)	Septicemia age 0-17	417
(5)	[Reserved for future use]	
(6)	[Reserved for future use]	
(7)	[Reserved for future use]	

S. Mental Diseases and Disorders

(1)	Treated with surgical procedure (ages 0+)	424
(2)	(Ages 0-17)	425, 427-429, 432
(3)	(Ages > 17)	425, 427-429, 432

T. Substance Use and Substance Induced Organic Mental Disorder ~~434, 435~~ 521, 523 DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69

U. [Reserved for future use]

V. Injuries, Poisonings, and Toxic Effects of Drugs

(1)	Treated with surgical procedure	439-443
(2)	[Reserved for future use]	
(3)	Traumatic injury	444-446
(4)	[Reserved for future use]	
(5)	Poisoning and toxic effects of drugs age > 17 with CC and allergic reactions	447-449
(6)	Poisoning and toxic effects of drugs age > 17 without CC	450
(7)	Poisoning and toxic effects of drugs age 0-17	451
(8)	Other injuries, poisoning,	

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and toxic effects	452-455
W. Burns	
(1) [Reserved for future use]	
(2) [Reserved for future use]	
(3) Full thickness with skin graft and extensive third degree burns	504-507, 508
(4) Burns without skin graft	~~508~~ 509-511
X. Factors Influencing Health Status	461-467
Y. ~~Bronchitis and Asthma~~	~~098~~
[Reserved for future use]	
Z. [Reserved for future use]	
AA. ~~Esophagitis, Gastroenteritis, Miscelaneous Digestive Disorders~~	~~184~~
[Reserved for future use]	
BB. [Reserved for future use]	
CC. Cesarean Sections	
(1) With complicating diagnosis	370
(2) Without complicating diagnosis	371
DD. Vaginal Delivery	
(1) [Reserved for future use]	
(2) Without complicating diagnosis or OR procedures	373
(3) With OR procedure	374, 375
(4) With complicating diagnosis	372
EE. [Reserved for future use]	
FF. Depressive ~~Neurosis~~ Neuroses, all ages	426
~~(1) (Age 0-17)~~	~~426~~
~~(2) (Age > 17)~~	~~426~~
GG. ~~Psychosis~~ Psychoses	
(1) (Ages 0-17)	430
(2) (Ages > 17)	430
HH. Childhood Mental Disorders	431

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II. Operating Room Procedure Unrelated to Principal Diagnosis		
(1) ~~[Reserved for future use]~~ Extensive OR	468	
(2) Nonextensive OR	476, 477	
~~(3) Extensive (Age 0-17)~~	~~468~~	
~~(4) Extensive (Age > 17)~~	~~468~~	
JJ. [Reserved for future use]		
KK. Extreme Immaturity		
(1) Weight < 1500 grams	386	76501-76505
	387	76500
(2) [Reserved for future use]		
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) Neonate respiratory distress syndrome	386	Codes in 386 except 76501-76505
LL. Prematurity with Major Problems		
(1) Weight < 1250 Grams	387	76511-76514
(2) Weight 1250 to 1749 Grams	387	76506, 76510, 76515, 76516
(3) Weight > 1749 Grams	387	Codes in DRG 387 except 76500, 76506, 76510-76516
MM. Prematurity without Major Problems	388	
NN. Full Term Neonates		
(1) With major problems	389	
(2) With other problems and neonates, died on day of birth	385, 390	DRG 385 includes neonates who expire at the birth hospital, and discharge date is the same as the birth date
OO. Multiple Significant Trauma	484-487	
PP. [Reserved for future use]		

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QQ. Normal Newborns ~~and Neonates Who Died on the Day of Birth~~	391~~, 385~~	~~DRG 385 includes neonates who expire at the birth hospital, and discharge date is the same as the birth date~~
RR. - TT. [Reserved for future use]		
UU. Organ Transplants and Tracheostomy		
(1) ~~[Reserved for future use]~~ Heart, kidney, liver, bone marrow, lung, pancreas and bowel transplants, and tracheostomy except for face, neck, and mouth diagnosis	103, 302, 480, 481, 483, 495, 512, 513	Bowel transplant includes any DRG with procedure 46.97
(2) ~~Kidney, pancreas, and bone marrow~~ [Reserved for future use]	~~302, 481, 191, 292~~	~~DRG 191, 292 includes 52.80-52.86 only~~
(3) ~~Heart, lung, liver, bowel transplants~~ [Reserved for future use]	~~103, 480, 495~~	~~Bowel transplant includes any DRG with procedure 46.99 and Revenue Code 811 or 812 only~~
VV. Reserved for future use		
WW. Human Immunodeficiency Virus	488-490	

C. Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part. The following diagnostic categories are for services provided within a rehabilitation hospital or a rehabilitation distinct part, regardless of program eligibility:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS
A. Nervous System Diseases and Disorders	001-035	except codes in XX
B.-G. [Reserved for future use]		

H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209-213, 216-220, 223-256, 471, 491, 496-503, 519, 520	except codes in XX
I.-QQ. [Reserved for future use]		
RR. Mental Diseases and Disorders/ Substance Use and Substance Induced Organic Mental Disorders	424-432, ~~434, 435~~ 521, 523	except codes in XX DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69
SS. Multiple Significant Trauma/ Unrelated OR Procedures	468, 476, 477, 484-487	Except codes in XX
TT. Other Conditions Requiring Rehabilitation Services	036-208 257-423, 439-455, 461-467, ~~472~~, 473, 475, 478-483, 488-490, 492-495, ~~504-511~~ 504-518	Except codes in XX
UU.-WW. [Reserved for future use]		
XX. Quadriplegia and Quadriparesis Secondary to Spinal Cord Injury	All DRGs	Includes all DRGs with ICD-9 diagnoses codes: 344.00-344.04 or 344.09 in combination with 907.2

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D. Diagnostic categories for neonatal transfers. The following diagnostic categories are for services provided to neonatal transfers at receiving hospitals with neonatal intensive care units, regardless of program eligibility:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS
A. - JJ. [Reserved for future use]		
KK. Extreme Immaturity and Tracheostomy		
(1) Weight < 750 Grams and tracheostomy	386,482, 483	76501, 76502
(2) Weight 750 to 999 Grams	386	76503
(3) Weight 1000 to 1499 Grams	386, 387	76504, 76505, 76500
(4) [Reserved for future use]		
(5) Neonate Respiratory Distress Syndrome	386	Codes for DRG 386 except 76501 to 76505
LL. Prematurity with Major Problems		
(1) Weight < 1250 Grams	387	76511-76514
(2) Weight 1250 to 1749 Grams	387	76506, 76510, 76515, 76516
(3) Weight 1250 to 1749 Grams	387	Codes ~~for~~ in DRG 387 except 76500, 76506, 76510-76516
MM. Prematurity without Major Problems Weight > 1749 Grams	388	
NN. Full Term Neonates		
(1) With major problems (age 0)	389	
(2) With other problems	390	
OO. - WW. [Reserved for future use]		

E. Additional DRG requirements.

1. Version ~~17~~ 19 of the Medicare grouper and DRG assignment to the diagnostic category must be used uniformly for all determinations of rates and payments.

2. The discharge status will be changed to "discharge to home" for DRG 433.

3. A diagnosis with the prefix "v57" will be excluded when grouping under item C..

4. Neonates transferred into a neonatal intensive care unit with a DRG assignment of DRG 482 or DRG 483, ~~the ICF-9-CM procedure codes 30.3, 30.4, 31.11, 31.21 and 31.29 will be excluded when grouping under~~

~~items A and B~~ age less than one year, will be grouped under item D.

5. The discharge status will be changed to "discharge to home" for all neonates in DRG 385, except for neonates that expire at the birth hospital and the discharge date is the same as the date of birth.

6. For payment of admissions that result from the unavailability of a home health nurse, and there is no acute episode of illness, and when physician orders from home remain in effect, the principal diagnosis will be identified as V58.89, Other Specified ~~Procedures and~~ Aftercare or 63.1, Medical Services in Home not Available.

7. ~~Payment for bowel transplants and pancreas transplants will be made only for admissions that result in the recipient receiving a transplant during that admission.~~ For neonates transferred into a neonatal intensive care unit within seven days of birth, with a principal diagnosis of congenital anomaly (ICD-9-CM code 740-759) and a secondary diagnosis of conditions originating in the perinatal period (ICD-9-CM code 760-779), the principal diagnosis and the first sequenced secondary diagnosis in the range 760-779 will be interchanged when grouping under item D.

8. For patients in DRG 386-390 and the age is greater than zero, the principal diagnosis from ICD-9-CM Chapter 15, Certain conditions originating in the perinatal period (diagnoses codes 760-779), will be excluded when grouping under items A and B.

9. For payment under DRG 521, alcohol/drug abuse or dependence with complications or comorbidities, payment is not made for patients engaged in alcohol and/or drug rehabilitation.

Hospital cost index or HCI. "Hospital cost index" or "HCI" means the factor annually multiplied by the allowable base year operating cost to adjust for cost changes.

Inpatient hospital costs. "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare but not to include the Medical Assistance hospital surcharge and without regard to adjustments in payments imposed by Medicare.

Inpatient hospital service. "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital, including outpatient services provided by the same hospital that directly precede the admission.

Local trade area hospital. "Local trade area hospital" means a MSA hospital with 20 or more Medical Assistance (including General Assistance Medical Care, a State-funded program) admissions in the base year that is located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota.

Long-term care hospital. "Long-term care hospital" means a Minnesota hospital or a metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that meets the requirements under Code of Federal Regulations, title 42, part 412, section 23(e).

Metropolitan statistical area hospital or MSA hospital. "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Non-metropolitan statistical area hospital or non-MSA hospital. "Non-metropolitan statistical area hospital" or "non-MSA hospital" means a Minnesota hospital not located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Operating costs. "Operating costs" means inpatient hospital costs excluding property costs.

Out-of-area hospital. "Out-of-area hospital" means a hospital that is located in a state other than Minnesota excluding MSA hospitals located in a county of the other state in which the county is contiguous to Minnesota.

Property costs. "Property costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes, and property insurance.

Rate year. "Rate year" means a calendar year from January 1 through December 31.

Rehabilitation distinct part. "Rehabilitation distinct part" means inpatient hospital services that are provided by a hospital in a unit designated by Medicare as a rehabilitation distinct part.

Relative value. "Relative value" means the mean operating cost within a diagnostic category divided by the mean operating cost in all diagnostic categories within a program at diagnostic category A or B or specialty group C or D. The relative value is calculated from the total allowable operating costs of all admissions. This includes the full, untruncated costs of all exceptionally high cost or long stay admissions. Due to this inclusion of all costs, the relative value is composed of two parts. The basic unit of the relative value adjusts for the cost of an average admission within the given diagnostic category. The additional component of the relative value consists of an adjustment to compensate for the costs of exceptionally high cost admissions occurring within the diagnostic category. This factor, when applied to the base rate and the day outlier rate, cause additional payment adjustments to be made to compensate for cost outliers typically found within the diagnostic category. Since all cost is included, the cost outlier threshold is the average cost and is set to pay a cost outlier adjustment for all admissions with a cost that is above the average. The amount of payment adjustment to the operating rate increases as the cost of an admission increases above the average cost.

Seven-county metropolitan area hospital. "Seven-county metropolitan area hospital" means a Minnesota hospital located in one of the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey , Scott, or Washington.

Transfer. "Transfer" means the movement of a recipient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation distinct part.

Trim point. "Trim point" means that number of inpatient days beyond which an admission is a day outlier.

SECTION 3.0 ESTABLISHMENT OF BASE YEARS

A. The base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.

B. The base year data will be moved forward three years beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995, except for 1997, or every one year if notice is provided at least six months prior to the rate year by the Department. For long-term care hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report. That base year will remain until it falls within the same period as other hospitals.

SECTION 4.0 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES

4.01 Determination of relative values. The Department determines the relative values of the diagnostic categories as follows:

A. Select Medical Assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.
B. Exclude the claims and charges in subitems (1) to (7):

(1) Medicare crossover claims;

(2) claims paid on a transfer rate per day according to Section 10.03;

(3) inpatient hospital services for which Medical Assistance payment was not made;

(4) inpatient hospital claims paid to a long-term care hospital;

(5) inpatient hospital services not covered by the Medical Assistance program on October 1 prior to a rebased rate year;

(6) inpatient hospital charges for noncovered days calculated as the ratio of noncovered days to total days multiplied by charges; and

(7) inpatient hospital services paid under Section 15.11.

C. Combine claims into the admission that generated the claim according to readmissions at Section 12.2.

D. Determine operating costs for each hospital admission using each hospital's base year data according to subitems (1) to (5).

(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost-to-charge ratio and add the products of all ancillary services. An ancillary operating cost-to-charge ratio will be adjusted for certified registered nurse anesthetist costs and charges if the hospital determines that certified registered nurse anesthetist services will be paid separately.

(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.

(4) Add subitems (1) to (3).

(5) Multiply the result of subitem (4) by the hospital cost index at Section 7.0 that corresponds to the hospital's fiscal year end.

E. Assign each admission and operating cost identified in item D, subitem (5), to the appropriate program or specialty group and diagnostic category.

F. Determine the mean cost per admission within each program and the rehabilitation distinct part specialty group for the program and rehabilitation distinct part specialty group admissions identified in item E by dividing the sum of the operating costs by the total number of admissions.

G. Determine the mean cost per admission within each program and rehabilitation distinct part specialty group diagnostic category identified in item E by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.

H. Determine the relative value for each diagnostic category by dividing item G by the corresponding result of item F within each program and the rehabilitation distinct part specialty group and round the quotient to five decimal places.

I. Determine the mean length of stay within each program and rehabilitation distinct part diagnostic category identified in item E by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.

J. Determine the day outlier trim point for each program and rehabilitation distinct part diagnostic category and round to whole days.

SECTION 5.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER

5.01 Adjusted base year operating cost per admission for Minnesota and local trade area hospitals. The Department determines the adjusted base year operating cost per admission by program and the rehabilitation distinct part speciality group for each hospital according to items A to D.

A. Determine and classify the operating cost for each admission according to Section 4.01, items A to E.